PRINTED: 10/14/2010 FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS409AGC 06/25/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5513 FLORA SPRAY STREET** FORGET ME NOT HOME CARE LLC LAS VEGAS, NV 89130 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 Y 000 **Initial Comments** The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal. state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 6/25/10. The facility received an annual survey grade of B. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for six Residential Facility for Group beds which provide care to elderly or disabled persons and/or persons with mental illnesses, Category II residents. The census at the time of the survey was five. Five resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed. The following deficiencies were identified: Y0251, Y0434, Y0435, Y0444, Y0693 and Y9999. Y 251 449.217(2) Storage of Food-Perishable foods Y 251 SS=E refrigerated

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

2. Perishable foods must be refrigerated at a temperature of 40 degrees Fahrenheit or less. Frozen foods must be kept at a temperature of 0

NAC 449.217

degrees or less.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
NVS409AGC				B. WING		06/25/2010			
			STREET ADD	ADDRESS, CITY, STATE, ZIP CODE					
EODGET ME NOT HOME CADE LLC				513 FLORA SPRAY STREET AS VEGAS, NV 89130					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
Y 251	Continued From page 1			Y 251					
	This Regulation is not met as evidenced by: Based on observation on 6/25/10, the facility failed to maintain the temperature below 0 degrees Fahrenheit or less for 1 or 3 freezers. Severity: 2 Scope: 2								
Y 434 SS=D	Y 434 SS=D 449.229(3) Emergency Drills			Y 434					
	record of each drill m	on must be performed ar schedule, and a writ ust be kept on file at th an 12 months after the	е						
	Based on record revieudid not ensure that m	.,	ity were						
Y 435 SS=F	449.229(4) Fire Extin	guisher; Inspection		Y 435					
	recharged and tagged	uishers must be inspect d at least once each ye the State Fire Marshall ions.	ar by						
	This Regulation is no	ot met as evidenced by	:						

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING _ NVS409AGC 06/25/2010

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FORGET ME NOT HOME CARE LLC		5513 FLORA SPRAY STREET LAS VEGAS, NV 89130				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 435	Y 435 Continued From page 2 Based on observation on 6/25/10, the facility failed to ensure that 2 of 2 facility fire extinguishers were inspected annually.		Y 435			
	Severity: 2 Scope: 3					
Y 444 SS=E	449.229(9) Smoke Detectors					
	NAC 449.229 9. Smoke detectors must be maintained in proper operating conditions at all times and must be tested monthly. The results of the tests pursuant to this subsection must be recorded and maintained at the facility.					
	This Regulation is not met as evidenced by Based on record review on 6/25/10, the facil did not ensure smoke detectors were tested out of the past 12 months (July, August, September, October, November and Decemof 2009).	lity 6				
	Severity: 2 Scope: 2					
Y 693 SS=E	449.2712(2) Oxygen-Caregiver monitor residability	dent	Y 693			
	NAC 449.2712 2. The caregivers employed by a residential facility with a resident who requires the use oxygen shall: (a) Monitor the ability of the resident to operative equipment in accordance with the orders physician. (b) Ensure That: (1) The resident's physician evaluates periodically the condition of the resident which	of ate s of a				

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